SECTION 3:

HOME RECORDS

INTRODUCTION TO HOME RECORDS

SUBMITTED TO THE DEPARTMENT

The following are to be completed and submitted to the regional certifying agent:

Upon Application:

- ☐ Application Part A

At Initial Certification Study:

- ☐ Application Part B

At Annual Recertification Survey or Desk Review:

- ☐ Renewal Application
- ☐ If more than one resident receiving care in the home requires nursing facility level of care, Exception Request to IDAPA 16.03.19.130
- ☐ If three or four residents are receiving care in the home, the following:
    - o Application to Exceed the Two Resident Limit
    - o Exception Request to IDAPA 16.03.19.100.03

Prior to Any New Admission:

- ☐ If for the first or second resident in the home, Request for New Admission
- ☐ If for the third or fourth resident in the home, the following:
    - o Application to Exceed the Two Resident Limit
    - o Exception Request to IDAPA 16.03.19.100.03
    - o Exception Request to IDAPA 16.03.19.130, if caring for more than one resident who requires nursing facility level of care

Within 3 Business Days of a Fire:

- ☐ Fire Incident Report

MAINTAINED BY THE PROVIDER

The following are to be completed and maintained in the home:

One Time (keep permanently):

- ☐ Certificate showing completion of a Department-approved medications course for the following individuals:
    - o The provider
    - o Any substitute caregiver
- ☐ Clearance of Department Criminal History and Background Check for the following individuals:
    - o The provider
    - o Any substitute caregiver
    - o Any adult member of the household, excluding the resident(s)
- ☐ Mortgage, deed or lease listing the name of the provider or the provider's spouse

- ☐ If the home uses a municipal water supply, a water bill
- ☐ If the home uses a municipal sewage disposal system, a sewer bill
- ☐ Electrical inspection by a licensed electrician or local/state electrical inspector stating all wiring in the home complies with applicable local code
    - o If the home uses only an all-electric heating system, the inspector should note such on the inspection report
- ☐ Proof the home is in a lawfully constituted fire district (e.g., letter from the fire district)
- ☐ Drawing of the home evacuation plan

Current (keep for 5 years):

- ☐ First aid and CPR certification for the following individuals:
    - o The provider
    - o Any substitute caregiver
- ☐ Ongoing Annual Training Log
- ☐ Proof of homeowner's or renter's insurance
- ☐ If the home uses a private water supply, the results of a water test showing an absence of bacterial contamination conducted at least annually
- ☐ If the home uses a nonmunicipal sewage system, proof that the septic tank has been pumped or that the system has been inspected and found in good working condition at least every 5 years
- ☐ Emergency Preparedness Log
- ☐ Fire Drill Summary (or video evidence, which is preferred by the Department)
    - o If caring for 1-2 residents, documentation of quarterly fire drills
    - o If caring for 3-4 residents or offering hourly adult care, documentation of monthly fire drills
- ☐ Proof any fuel-fired heating system (e.g., gas furnace/fireplace, wood/pellet stove) in the home has been inspected at least annually by a professional who services such systems and found to be in good working condition
- ☐ Proof that 5 lb. 2A:10B:C fire extinguishers (one for each level of the home) have been serviced or purchased at least every 12 months
- ☐ Recent phone bill
- ☐ Emergency contacts, either:
    - o Programmed into the phone
    - o Emergency Phone Numbers posted near the phone
- ☐ If offering hourly adult care (i.e., hourly respite care to adults who are not residents of the home):
    - o Hourly Adult Care Enrollment Contract for each hourly adult care participant
    - o Hourly Adult Care Service Log for each day on which hourly adult care provided

CERTIFIED
FAMILY HOME PROGRAM

APPLICATION | PART A

Part A is submitted to initiate the application process or a current provider's move to a new home.

IDAHO DEPARTMENT OF HEALTH & WELFARE

SECTION 1: APPLICANT INFORMATION

The applicant is the adult responsible for maintaining the home and providing care to the resident(s).

a. Full Legal Name:		b. Date of Birth:
c. Other Names Used *(maiden, married, etc.):*		
d. Telephone Number: ( )	e. Email Address:	
f. Mailing Address:		
g. Mailing City:	h. Mailing State:	i. Mailing ZIP:

j. Are you an existing certified family home provider moving to a new residence and requesting temporary certification? Yes ☐ No ☐

If yes, please include with this application:

- A copy of a recent (within one year) electrical inspection report for the new residence, and
- If the home is equipped with fuel-fired heating devices (e.g., wood stove, gas furnace, etc.), recent (within one year) inspection reports for such devices.

k. Do you or anyone else living in your home have a disease, disability, or other mental and/or physical health condition that could impact your ability to safely provide care to the resident(s)? Yes ☐ No ☐

If yes, please describe:

l. Do you currently hold a foster care license? Yes ☐ No ☐

m. Are you currently being investigated, in any jurisdiction, for a crime or concerns related to a health care, child care, or foster care certificate or license? Yes ☐ No ☐

If yes, please describe including the entity conducting the investigation:

_____
_____
_____
_____

n. Have you had a health care, child care, or foster care certificate or license denied or revoked in the past, or other disciplinary action taken or in the process of being taken in any jurisdiction? Yes ☐ No ☐

If yes, please describe including the name and type of agency/facility, and the date and type of action:

_____
_____
_____
_____

o. Have you ever been convicted of fraud, gross negligence, abuse, assault, battery, or exploitation? Yes ☐ No ☐

Have you been convicted of any other criminal offense within the past five (5) years? Yes ☐ No ☐

p. Have you been ordered by a court not to operate a health facility, residential care or assisted living facility, or certified family home? Yes ☐ No ☐

q. Are you listed on the Child Abuse, Adult Protection, or Sexual Offender Registries? Yes ☐ No ☐

r. Are you listed on the Medicaid Exclusion List? Yes ☐ No ☐

SECTION 2: HOME INFORMATION

The home is the residential setting where the applicant lives with the resident(s).

a. Physical Address:		b. Physical ZIP:
c. Physical City:	d. Physical State:	e. Number in Household:
f. Ownership: The applicant or applicant's spouse owns the home. ☐ or The applicant or applicant's spouse rents the home. ☐		g. Number of Bedrooms: h. Number of Bathrooms:
i. Type: Stick Built ☐ or Manufactured/Modular ☐ Year Built:	j. Is the home located within a lawfully constituted fire district? Yes ☐ No ☐	
k. Is the home served by an all-weather road open to motor vehicles year-round? Yes ☐ No ☐		
l. Is the home equipped with any adaptive equipment (e.g., ramps, grab bars, etc.)? Yes ☐ No ☐ *If yes, please list:*		

SECTION 3: RESIDENT INFORMATION

A resident is an adult needing care. If there is no prospective resident, leave this section blank. If there is a second prospective resident, repeat this section on a separate sheet of paper and submit it with Application Part A.

a. Full Legal Name:		b. Date of Birth:
c. Gender: Male ☐ or Female ☐	d. Relationship to Applicant:	
e. Diagnoses/Behaviors: _____		
f. Payer Source (*select only one; share of cost is Public Assistance*): Public Assistance ☐ Private Pay ☐		
g. Does the resident have a legally appointed guardian or a power of attorney (POA)? Yes ☐ No ☐ If yes, Guardian/POA Name: _____ Telephone Number: (_____)_____		
h. Is the resident's name listed on the lease/deed/mortgage of the applicant's home? Yes ☐ No ☐		
i. Does the resident have any physical or sensory impairments (e.g., non-ambulatory, blind, etc.)? Yes ☐ No ☐ *If yes, please describe:*		

SECTION 4: OTHER MEMBERS OF THE HOUSEHOLD ***List all other members of the household below, except the applicant.***

1a. Full Legal Name:	1b. Date of Birth:
2a. Full Legal Name:	2b. Date of Birth:
3a. Full Legal Name:	3b. Date of Birth:
4a. Full Legal Name:	4b. Date of Birth:
5a. Full Legal Name:	5b. Date of Birth:
6a. Full Legal Name:	6b. Date of Birth:
7a. Full Legal Name:	7b. Date of Birth:

Continue on a separate sheet if there are additional members of the household.

SECTION 5: APPLICATION VERIFICATIONS

a. My signature below means that by submitting this application, I understand that I will be invoiced for the $150.00 non-refundable application fee, unless I am an existing certified family home provider moving to a new residence. I also understand that payment of the application fee is required before attending New Provider Orientation.	
b. My signature below means that I hereby assure the Department that I have thoroughly read and reviewed Idaho Administrative Procedures Act (IDAPA) 16, Title 03, Chapter 19, "Rules Governing Certified Family Homes," or that I will read and review these rules, and I am prepared to comply with all provisions in this chapter.	
c. My signature below means that I hereby confirm that I am not under the control or influence of any person who is described in Subsections 113.01-07 of IDAPA 16.03.19 (i.e., a person who would answer "yes" to any of the questions in Subsections 1.m-r on this application).	
d. My signature below means that I hereby certify the information provided in this application is true and correct to the best of my knowledge.	
e. Applicant Signature:	f. Date:
g. Certifying Agent Signature*:	h. Date**:

* *The certifying agent will sign and date Application Part A when it is determined to be complete and the applicant's information is data-entered into the program database.*

** *The Department reserves the right to terminate the application if the applicant has not attended New Provider Orientation within six (6) months of this date on Application Part A.*

CERTIFIED
FAMILY HOME PROGRAM

APPLICATION | PART B

Part B is submitted to complete the application process.

IDAHO DEPARTMENT OF HEALTH & WELFARE

SECTION 1: APPLICANT INFORMATION

The applicant is the adult responsible for maintaining the home and providing care to residents.

a. Full Legal Name:	b. Date of Birth:
c. Date Attended New Provider Orientation:	d. Date Completed Medications Course:
e. Expiration of First Aid Certificate:	f. Expiration of Adult CPR Certificate:

g. List any special training, education, licensure, certification, or experience related to caregiving, if any: _____

_____

h. Date Cleared Department of Health & Welfare Criminal History and Background Check:

i. What languages do you speak?

- ☐ English
- ☐ Spanish
- ☐ French
- ☐ German
- ☐ Portuguese
- ☐ Romanian
- ☐ Italian
- ☐ Serbo-Croatian
- ☐ Russian
- ☐ Cantonese or Mandarin
- ☐ Japanese
- ☐ Other – please list:
- ☐ Vietnamese
- ☐ Nepali
- ☐ Tagalog
- ☐ American Sign Language
- ☐ Other Native North American

j. Do you need an English interpreter? Yes ☐ No ☐

If yes, please provide:
Name of Interpreter: _____
Phone Number: (____)_____

k. Do you intend to be employed outside the home? Yes ☐ No ☐

If yes, please provide:
Employer Name: _____
Work Number: (____)_____
Work Address: _____
_____

DAY	HOURS
Sunday	_____
Monday	_____
Tuesday	_____
Wednesday	_____
Thursday	_____
Friday	_____
Saturday	_____

SECTION 2: SUBSTITUTE CARE

Substitute caregivers are adults who provide care to residents in the applicant's absence. Incidental supervision may be provided by other adults without substitute caregiver qualifications, but incidental supervision is limited to four (4) hours per week and does not include care to residents. List any substitute caregivers below.

1a. Full Legal Name:	1b. Date of Birth:
1c. Expiration of First Aid:	1d. Expiration of Adult CPR:
1e. Date Completed Medications Course:	1f. Date Fingerprinted for DHW Check:

2a. Full Legal Name:	2b. Date of Birth:
2c. Expiration of First Aid:	2d. Expiration of Adult CPR:
2e. Date Completed Medications Course:	2f. Date Fingerprinted for DHW Check:

Continue on a separate sheet if there are additional substitute caregivers.

SECTION 3: SERVICES

The applicant is offering the following services in the home (check all that apply):

a. Care to residents with the following conditions/diagnoses:	b. Accommodations for the following:	
☐ Alzheimer's or Other Dementia	☐ Non-relative Residents	☐ Female Residents Only
☐ Developmental Disability	☐ Emergency Placements	☐ Male Residents Only
☐ Elderly	☐ Alternate Care	☐ Residents who are Deaf
☐ Mental Illness	☐ Hourly Adult Care	☐ Residents who are Blind
☐ Physical Disability	☐ Residents with Pets	☐ Non-ambulatory Residents
☐ Traumatic Brain Injury	☐ Residents who Smoke	☐ Non-English-speaking Residents Language: _____
	☐ Other – Please describe: _____	

SECTION 4: OTHER MEMBERS OF THE HOUSEHOLD

List all other members of the household below, except the applicant. Any other adult members of the household, except for the resident(s)—that is, the adults needing care—must complete a self-declaration form, must be fingerprinted, and must not have any designated crimes listed in IDAPA 16.05.06 "Criminal History and Background Checks."

1a. Full Legal Name:	1b. Date of Birth:
1c. Gender: Male ☐ or Female ☐	1d. Relationship to Applicant:
1e. Date Fingerprinted for DHW Criminal History and Background Check (if not a resident or minor):	

2a. Full Legal Name:	2b. Date of Birth:
2c. Gender: Male ☐ or Female ☐	2d. Relationship to Applicant:
2e. Date Fingerprinted for DHW Criminal History and Background Check (if not a resident or minor):	

3a. Full Legal Name:	3b. Date of Birth:
3c. Gender: Male ☐ or Female ☐	3d. Relationship to Applicant:
3e. Date Fingerprinted for DHW Criminal History and Background Check (if not a resident or minor):	

4a. Full Legal Name:	4b. Date of Birth:
4c. Gender: Male ☐ or Female ☐	4d. Relationship to Applicant:
4e. Date Fingerprinted for DHW Criminal History and Background Check (if not a resident or minor):	

5a. Full Legal Name:	5b. Date of Birth:
5c. Gender: Male ☐ or Female ☐	5d. Relationship to Applicant:
5e. Date Fingerprinted for DHW Criminal History and Background Check (if not a resident or minor):	

6a. Full Legal Name:	6b. Date of Birth:
6c. Gender: Male ☐ or Female ☐	6d. Relationship to Applicant:
6e. Date Fingerprinted for DHW Criminal History and Background Check (if not a resident or minor):	

7a. Full Legal Name:	7b. Date of Birth:
7c. Gender: Male ☐ or Female ☐	7d. Relationship to Applicant:
7e. Date Fingerprinted for DHW Criminal History and Background Check (if not a resident or minor):	

Continue on a separate sheet if there are additional members of the household.

SECTION 5: HOME OWNERSHIP This section pertains to the home specified in Application Part A, Section 2, which should have previously been submitted to the certifying agent. The applicant must answer "Yes" to each question in this section in order for the application to be considered complete. Does the applicant have available evidence of the following?

a. The lease, deed, or mortgage listing the name of the applicant or applicant's spouse:	Yes ☐	No ☐
b. The current homeowner's or renter's insurance policy:	Yes ☐	No ☐

SECTION 6: UTILITIES This section pertains to the home specified in Application Part A, Section 2, which should have previously been submitted to the certifying agent. The applicant must answer "Yes" to each question in this section in order for the application to be considered complete. Does the applicant have available evidence of the following?

a. City water bill, or, if using a non-municipal water source (e.g., private well) in the home, a current statement from the local environmental health agency that the water supply meets legal standards or, if the local environmental health agency cannot provide this information, a statement to that affect in writing from the local environmental health agency:	Yes ☐	No ☐
b. City sewer bill, or, if using a non-municipal sewage disposal system (e.g., septic tank), a current statement from the local environmental health agency that the sewage system meets legal standards, or if the local environmental health agency cannot provide this information, a statement to that affect in writing from the local environmental health agency:	Yes ☐	No ☐
c. Dependable phone service:	Yes ☐	No ☐

SECTION 7: NON-MUNICIPAL WATER OR SEWER This section pertains to the home specified in Application Part A, Section 2, which should have previously been submitted to the certifying agent. Leave subsections blank that do not apply. Does the applicant have available evidence of the following?

a. If using a non-municipal water source (e.g., private well) in the home, a recent (within one year) report from an accredited laboratory showing an absence of bacterial contamination:	Yes ☐	No ☐
b. If using a septic tank, proof that the tank has been pumped recently (within one year) or a statement from a company permitted to clean septic tanks that pumping was not necessary:	Yes ☐	No ☐

SECTION 8: EMERGENCY PREPAREDNESS This section pertains to the home specified in Application Part A, Section 2, which should have previously been submitted to the certifying agent. The applicant must answer "Yes" to each question in this section in order for the application to be considered complete. Does the applicant have available evidence of the following?

a. Proof that the home is in a lawfully constituted fire district (e.g., letter from the fire district):	Yes ☐	No ☐
b. A home fire evacuation plan drawing with at least 2 routes of escape from each room, an outside meeting area after evacuation, and the person responsible for relaying information to firefighters:	Yes ☐	No ☐
c. A written emergency plan addressing confinement in the home (e.g., shelter-in-place orders) for at least 72 hours and considering, at minimum, adequate food, water, and medications:	Yes ☐	No ☐
d. A written emergency plan addressing evacuation orders from the home (e.g., due to wildfire) including pre-arranged plans to shelter within the local community and in a town outside the local community, and considering necessary supplies to be kept in a state of preparedness:	Yes ☐	No ☐
e. A written procedure for any situation in which the applicant becomes incapacitated:	Yes ☐	No ☐
f. Power to a phone in the event of an extended electrical outage (most landlines will still function during an outage; VOIP and cell phones will need back-up power of some kind, such as an uninterruptible power supply, generator, or portable power bank):	Yes ☐	No ☐

SECTION 9: FIRE/LIFE SAFETY This section pertains to the home specified in Application Part A, Section 2, which should have previously been submitted to the certifying agent. Leave subsections blank that do not apply. Does the applicant have available evidence of the following?

a. Functioning smoke alarms installed in each sleeping room, each hallway, and on each level:	Yes ☐	No ☐
b. Functioning carbon monoxide alarms on each level of the home if the home is equipped with gas or other fuel-burning appliances or devices, or has an enclosed, attached garage:	Yes ☐	No ☐
c. Recent (within one year) inspections of all fuel-fired heating devices (e.g., wood or pellet stoves, gas furnaces or fireplaces, etc.) by persons in the business of servicing such systems, indicating that the system is in good working order (if heating in the home is provided entirely by an all-electric system, please have the electrical inspector indicate so on the electrical inspection):	Yes ☐	No ☐
d. A recent (within one year) electrical inspection conducted by a licensed electrician or the local/state electrical inspector indicating that all wiring in the home complies with local code:	Yes ☐	No ☐
e. Receipts from recent (within one year) purchases of 5 lb. dry chemical multipurpose 2A:10B:C portable fire extinguishers, one for each level of the home, or a recent service inspection of such:	Yes ☐	No ☐
f. Firearms, if present in the home, are kept locked:	Yes ☐	No ☐

SECTION 10: APPLICATION VERIFICATIONS

a. My signature below means that I have thoroughly read Idaho Administrative Procedures Act (IDAPA) 16, Title 03, Chapter 19, "Rules Governing Certified Family Homes," and I am prepared to comply with all provisions in this chapter.	
b. My signature below means that I hereby agree that my home, residents living in my home, and all records pertaining to the residents and my home's operation will be accessible to the Department at all times for the purposes of inspection, with or without prior notice.	
c. My signature below means that I hereby consent to the release of information affecting my eligibility for certification as a certified family home provider to the Department by any individual or agency.	
d. My signature below means that I hereby certify the information provided in this application is true and correct to the best of my knowledge.	
e. Applicant Signature:	f. Date:

CERTIFIED
FAMILY HOME PROGRAM

RENEWAL APPLICATION

Renewal Application is required annually for existing providers.

IDAHO DEPARTMENT OF HEALTH & WELFARE

SECTION 1: PROVIDER AND HOME INFORMATION

The provider is the adult responsible for maintaining the certified family home and providing care to residents. The home is the residential setting where the provider lives with the residents.

a. Full Legal Name:		b. Certificate No.:
c. Telephone Number: ( )	d. Email:	
e. Mailing Address:		
f. Mailing City:	g. Mailing State:	h. Mailing ZIP:
i. Home Address (*if different than mailing address*):		
j. Home City:	k. Home State:	l. Home ZIP:

m. Are you employed outside the home? Yes ☐ No ☐

If yes, please provide:
Employer Name: _____
Work Number: (_____)_____
Work Address: _____
_____

DAY	*HOURS*
Sunday	_____
Monday	_____
Tuesday	_____
Wednesday	_____
Thursday	_____
Friday	_____
Saturday	_____

SECTION 2: OPTIONAL SERVICES

The provider is offering the following services in the home (check all that apply):

a. Care to residents with the following conditions/diagnoses:

- ☐ Alzheimer's or Other Dementia
- ☐ Developmental Disability
- ☐ Elderly
- ☐ Mental Illness
- ☐ Physical Disability
- ☐ Traumatic Brain Injury

b. Accommodations for the following:

- ☐ Non-relative Residents
- ☐ Emergency Placements
- ☐ Alternate Care
- ☐ Hourly Adult Care
- ☐ Residents with Pets
- ☐ Residents who Smoke
- ☐ Other – *Please describe:* _____
- ☐ Female Residents Only
- ☐ Male Residents Only
- ☐ Residents who are Deaf
- ☐ Residents who are Blind
- ☐ Non-ambulatory Residents
- ☐ Non-English-speaking Residents Language: _____

SECTION 3: SUBSTITUTE CARE

Substitute caregivers are adults who provide care to residents in the provider's absence. Incidental supervision may be provided by other adults without substitute caregiver qualifications, but incidental supervision is limited to four (4) hours per week and does not include care to residents. ***List any substitute caregivers below.***

1a. Full Legal Name:	1b. Date of Birth:
2a. Full Legal Name:	2b. Date of Birth:
3a. Full Legal Name:	3b. Date of Birth:
4a. Full Legal Name:	4b. Date of Birth:

Continue on a separate sheet if there are additional substitute caregivers.

SECTION 4: CURRENT MEMBERS OF THE HOUSEHOLD

List everyone living in the home. *The term "resident" refers to a vulnerable adult living in the home and receiving care from the provider.*

1a. Full Legal Name:		1b. Date of Birth:
1c. Male ☐ or Female ☐	1d. Relationship to Provider:	1e. CFH Resident? Yes ☐ No ☐

2a. Full Legal Name:		2b. Date of Birth:
2c. Male ☐ or Female ☐	2d. Relationship to Provider:	2e. CFH Resident? Yes ☐ No ☐

3a. Full Legal Name:		3b. Date of Birth:
3c. Male ☐ or Female ☐	3d. Relationship to Provider:	3e. CFH Resident? Yes ☐ No ☐

4a. Full Legal Name:		4b. Date of Birth:
4c. Male ☐ or Female ☐	4d. Relationship to Provider:	4e. CFH Resident? Yes ☐ No ☐

5a. Full Legal Name:		5b. Date of Birth:
5c. Male ☐ or Female ☐	5d. Relationship to Provider:	5e. CFH Resident? Yes ☐ No ☐

6a. Full Legal Name:		6b. Date of Birth:
6c. Male ☐ or Female ☐	6d. Relationship to Provider:	6e. CFH Resident? Yes ☐ No ☐

Continue on a separate sheet if there are additional members of the household.

SECTION 5: HOUSEHOLD CHANGES

List everyone who has moved in or out of the home in the last year.

1a. Full Legal Name:		1b. Date of Birth:
1c. Gender: Male ☐ or Female ☐	1d. Relationship to Provider:	
1e. Move-in Date:	1f. Move-out Date:	1g. CFH Resident? Yes ☐ No ☐

2a. Full Legal Name:		2b. Date of Birth:
2c. Gender: Male ☐ or Female ☐	2d. Relationship to Provider:	
2e. Move-in Date:	2f. Move-out Date:	2g. CFH Resident? Yes ☐ No ☐

Continue on a separate sheet if additional members of the household have moved in/out in the last year.

SECTION 6: APPLICATION VERIFICATION

a. My signature below means that I hereby request recertification as a certified family home.	
b. My signature below means that I hereby confirm that all substitute caregivers, other adults currently living in my home other than the resident(s), and I have not been convicted of a misdemeanor or felony since last clearing a Department criminal history and background check.	
c. My signature below means that I hereby certify the information provided in this application is true and correct to the best of my knowledge.	
d. Provider Signature:	e. Date:

EXCEPTION REQUEST FORM

PROVIDER

The provider is the adult responsible for ensuring compliance with rules governing certified family homes.

Provider Name:		Telephone:
Address:		
City:	State:	ZIP:

RULE

The rule for which the provider is requesting an exception.

Rule Reference: IDAPA 16, Title 03, Chapter 19, Section/Subsection:

JUSTIFICATION

Narratives that justify to the Department reasons for granting an exception to the rule identified above.

Good Cause/Extenuating Circumstance: *Please explain why you are seeking an exception, including why your specific situation makes it difficult for you to meet the rule.*_____
Compensating Factors: *Please explain how you will ensure the safety and wellbeing of your resident(s) in place of complying with the rule.*_____

SPECIAL CONDITIONS (To be completed by Department staff only)

Requirements that will be in place as conditions for the provider to operate the certified family home in non-compliance with the rule identified above.

RESIDENT ACKNOWLEDGEMENT

Confirmation that the residents have been made aware of and agree in principle to the request for this exception.

My signature indicates the following:

- I have been informed of this exception request;
- I understand an exception to this rule may affect my living arrangement;
- I have been informed or will be informed of any special conditions in connection to this exception;
- I am competent to make choices about my living arrangement;
- I request this specific living arrangement; and
- I have not been coerced into making this request.

RESIDENT NAME(S)	RESIDENT OR REPRESENTATIVE SIGNATURE(S)

APPLICATION VERIFICATION

Confirmation that the provider agrees to abide by the special conditions and ensure the health and safety of residents.

In requesting this exception, I am assuring that the health and safety of the residents will not be jeopardized if the exception is granted.	
I agree to abide by any special conditions the Department attaches to granting this exception.	
I understand that this exception expires as indicated below, and I must submit a new request to extend this exception upon its expiration. If an exception expires without renewal, I will comply with the rule.	
I understand that should the Department grant this exception, it is not considered a precedent and will not be given any force or effect in any other proceeding.	
Provider Signature:	Date:

DEPARTMENT DETERMINATION (To be completed by Department staff only)

The Department's review and determination of whether or not to grant this request for an exception

Determination: This request for an exception is ☐ Approved ☐ Denied	
Effective Date:	Expiration Date*:
*If there is no expiration date, the Department is granting a permanent waiver to the provider for this rule.	
This exception is effective as indicated above unless the Department revokes this variance or waiver.	
Program Manager Signature:	Date:

CERTIFIED
FAMILY HOME PROGRAM

REQUEST FOR NEW ADMISSION

The Request for New Admission is submitted for Department approval of a prospective resident.

IDAHO DEPARTMENT OF HEALTH & WELFARE

PROVIDER INFORMATION

The provider is the adult responsible for maintaining the home and providing care to the resident(s).

Full Legal Name:		Certificate No.:
Telephone Number: ( )	Email Address:	
What specific training and/or experience does the provider have that ensures adequate care at the levels or types of services required to meet the prospective resident's needs can be provided? _____ _____ _____ _____		

HOME INFORMATION

The home is the residential setting where the provider lives with the resident(s).

Physical Address:		
Physical City:	Physical State:	Physical ZIP:
Is the home equipped with adaptive equipment (e.g., ramps, grab bars, etc.)? Yes ☐ No ☐ If yes, please list: _____ _____		Current # in Household:
		Number of Bedrooms:
		Number of Bathrooms:
Has the provider attached a copy of the home's floor plan indicating each resident's sleeping room (including the room's square footage) and potential egress/ingress barriers? Yes ☐ No ☐		

STAFFING INFORMATION

The provider is the adult primarily responsible for maintaining the home and providing care to the resident(s). Qualified substitute caregivers (i.e., current CPR/First Aid certification, medication course, and cleared Department criminal history and background check) may provide care to residents when the provider is unavailable for up to 30 consecutive days. Regular staff may not have unsupervised contact with residents without a criminal history check.

Is the provider employed outside the home? Yes ☐ No ☐

If yes, please provide:
Employer Name: _____
Work Number: (____)_____
Work Address: _____
_____

DAY	HOURS
Sunday	_____
Monday	_____
Tuesday	_____
Wednesday	_____
Thursday	_____
Friday	_____
Saturday	_____

SUBSTITUTE CAREGIVER OR REGULAR STAFF NAME	SCHEDULE

PROSPECTIVE RESIDENT INFORMATION

The prospective resident is the vulnerable adult for whom the provider is requesting approval to admit to the home. Unless admitted on an emergency basis per IDAPA 16.03.19.260.03.a., the prospective resident must not move into the provider's home until this request is approved by the Department.

Full Legal Name:	Date of Birth:
Gender: Male ☐ or Female ☐	Relationship to Provider:
Diagnoses/Behaviors: _____	
Payment Program: ☐ Aged & Disabled Waiver, Medicare/Medicaid Coordinated Program, or Idaho Medicaid Plus ☐ Developmental Disabilities Waiver, or Self Direction ☐ Private Pay	
Does the resident have a legal guardian or a durable power of attorney (POA) for health care? Yes ☐ No ☐ If yes, Representative Name: _____ Telephone Number: (____)_____	
Does the resident have any physical or sensory impairments (e.g., non-ambulatory, blind, etc.)? Yes ☐ No ☐ If yes, please describe:	
Has the provider reviewed and attached a copy of the resident's recent history and physical exam from the resident's health care professional reflecting the resident's current health status? Yes ☐ No ☐	
Has the provider reviewed and attached a copy of the resident's current medications and treatments, and ensured lawful assistance with such can be offered by the home? Yes ☐ No ☐	
If applicable, has the provider reviewed and attached a copy of the resident's plan of service from another health care setting, if one exists, in effect within the previous six (6) months? Yes ☐ No ☐	

EXISTING RESIDENT INFORMATION

Leave blank if not applicable. An existing resident is a vulnerable adult already receiving services in the provider's home. If both the prospective admit and an existing resident are nursing facility level of care, the provider must also submit an Exception Request to IDAPA 16.03.19.130 with this request.

Full Legal Name:	Date of Birth:
Gender: Male ☐ or Female ☐	Relationship to Provider:
Diagnoses/Behaviors: _____	
Payment Program: ☐ Aged & Disabled Waiver, Medicare/Medicaid Coordinated Program, or Idaho Medicaid Plus ☐ Developmental Disabilities Waiver, or Self Direction ☐ Private Pay	
Required Number of Daily Hands-on Care Hours per the Assessment or Program:	

ADMISSION REQUEST AND DECISION

Anticipated Date of Admission:	Admitted on an Emergency Basis? Yes ☐ No ☐
My signature below means I certify information provided in this request is true and correct to the best of my knowledge.	
Provider Signature:	Date:
To Be Completed by the Department	
Is placement of the requested new admission approved?* Yes ☐ No ☐	
Certifying Agent Signature:	Date:

*The certifying agent must notify the provider of the Department's decision within five (5) business days of receipt of this request. When verbal notification is given, return this completed form to the provider within ten (10) business days. If approved and the new admit is receiving public assistance, also provide a copy of this form to Regional Medicaid Services.

CERTIFIED
FAMILY HOME PROGRAM

APPLICATION TO EXCEED THE TWO RESIDENT LIMIT

IDAHO DEPARTMENT OF HEALTH & WELFARE

Provider's Name:	Phone:	Date:
Address:		
NUMBER OF PEOPLE LIVING IN THE HOME (Please do NOT include your resident(s) here.)		
Number of Adults	Number of Children	Children's Ages

EMPLOYMENT STATUS OF EACH CAREGIVER

Other gainful employment?	NO	YES	If Yes - where, which days and what hours?
Caregiver #1 (Please list name below)			
Caregiver #2 (Please list name below)			

QUALIFICATIONS OF EACH CAREGIVER Please include dates of certifications.

Caregiver #1	
Caregiver #2	

List any further caregivers on a separate sheet.

CURRENT / PROPOSED RESIDENTS AND CARE REQUIRED

Attach copies of the current assessment (e.g., Findings, SIS), plan of service, history & physical exam, and medication list.

Resident #1 Name:	Birth Date:	Sex:
Payer: ❑ A&D Waiver ❑ DD Waiver ❑ Private Pay	Hours of direct care needed per day?	
Does the resident have a legal guardian? ❑ No - Please provide an emergency contact name & phone number for resident: ❑ Yes - Please provide the guardian's name and phone number:	Diagnoses / Behaviors / Special Needs:	

Resident #2 Name:	Birth Date:	Sex:
Payer: ❑ A&D Waiver ❑ DD Waiver ❑ Private Pay	Hours of direct care needed per day?	
Does the resident have a legal guardian? ❑ No - Please provide an emergency contact name & phone number for resident: ❑ Yes - Please provide the guardian's name and phone number:	Diagnoses / Behaviors / Special Needs:	

Resident #3 Name:	Birth Date:	Sex:
Payer: ❑ A&D Waiver ❑ DD Waiver ❑ Private Pay	Hours of direct care needed per day?	
Does the resident have a legal guardian? ❑ No - Please provide an emergency contact name & phone number for resident: ❑ Yes - Please provide the guardian's name and phone number:	Diagnoses / Behaviors / Special Needs:	

Resident #4 Name:	Birth Date:	Sex:
Payer: ❑ A&D Waiver ❑ DD Waiver ❑ Private Pay	Hours of direct care needed per day?	
Does the resident have a legal guardian? ❑ No - Please provide an emergency contact name & phone number for resident: ❑ Yes - Please provide the guardian's name and phone number:	Diagnoses / Behaviors / Special Needs:	

DESCRIPTION OF YOUR HOME

Please provide a sketch of your home's floor plan that identifies the bedrooms listed below.

Bedrooms for Resident Use	Room's Square Footage	Proposed Occupant(s)
Bedroom #1		
Bedroom #2		
Bedroom #3		
Bedroom #4		

My signature below certifies that I have read, understand, and will comply with the rules governing exceptions to the two-bed limit in my Certified Family Home.

Signature of Provider Date

** PLEASE NOTE **

An Exception Request to IDAPA 16.03.19.100.03 must accompany this form. If more than one resident requires nursing facility level of care, also include IDAPA 16.03.19.130.

ONGOING ANNUAL TRAINING LOG

Per IDAPA 16.03.19.116, the provider must document a minimum of eight (8) hours of ongoing, relevant training in the provision of supervision, services, and care. The first year of certification, these training requirements have already been met through the course of the initial certification process; every year thereafter the provider must complete this log. Providers who simultaneously care for three (3) residents must obtain a minimum of 12 hours of annual ongoing training; that requirement increases to a minimum of 16 hours for providers who simultaneously care for four (4) residents.

At least half of the type of training hours must be interactive (i.e., able to ask questions of a live instructor in real-time); the remaining hours may be independent study. Additionally, at least half the content of training hours must be resident-specific; the remaining hours may be general topics related to caregiving, health, and safety. Up to two (2) hours of CPR/First Aid training may account for general topics.

Provider Name:	Year:

Training Date	Topic	Source (instructor or author)	Type	Content	Hours
			☐ Interactive ☐ Independent	☐ Resident Specific ☐ General	
			☐ Interactive ☐ Independent	☐ Resident Specific ☐ General	
			☐ Interactive ☐ Independent	☐ Resident Specific ☐ General	
			☐ Interactive ☐ Independent	☐ Resident Specific ☐ General	
			☐ Interactive ☐ Independent	☐ Resident Specific ☐ General	
			☐ Interactive ☐ Independent	☐ Resident Specific ☐ General	
			☐ Interactive ☐ Independent	☐ Resident Specific ☐ General	
			☐ Interactive ☐ Independent	☐ Resident Specific ☐ General	

EMERGENCY PREPAREDNESS LOG

MONTHLY

Test All Smoke and (if applicable) Carbon Monoxide Alarms:
Press the test button on the unit until it sounds the alarm.

Date Tested	Provider Initials

QUARTERLY – EVERY 3 MONTHS

Examine All Fire Extinguishers:
Extinguishers must be mounted and free of damage. Seals must be unbroken. Safety pins must be in place. Examination must include unmounting, turning upside down, and remounting right side up.

Date Extinguishers Examined	Provider Initials

SEMI-ANNUALLY – EVERY 6 MONTHS

Replace Batteries in All Smoke and Carbon Monoxide Alarms	
Date Replaced	**Provider Initials**

Review Emergency Preparedness Policies and Procedures	
Date Reviewed	**Provider Initials**

FIRE DRILL SUMMARY

Practicing fire drills will help ensure individuals living in Certified Family Homes have the knowledge and experience to safely escape a fire. This form, if properly completed, meets the requirements for a record of fire drill in accordance with IDAPA 16.03.19.600.05. Providers are encouraged to show video documentation of fire drills to the certifying agent in lieu of completing this form. Fire drills are required quarterly for providers caring for one or two residents; providers caring for three or four residents or offering hourly adult care must conduct fire drills on a monthly basis.

Date:	Start Time: A.M. ☐ P.M. ☐	End Time: A.M. ☐ P.M. ☐
Length of time for all persons to evacuate the home:		
Caregivers Participating:		

Residents/Hourly Adult Care Participants:	Response:

Problems Encountered / Comments:

During the Fire Drill--	Yes	No
Were individuals closing the doors upon exiting rooms?		
Were individuals remaining calm and proceeding towards the nearest exit?		
Were individuals assembling at the designated meeting place?		
Was a head-count of all individuals in the home taken at the designated meeting place?		

EMERGENCY PHONE NUMBERS

FIRE - AMBULANCE - POLICE

9-1-1

POISON CONTROL..... 1-800-222-1222
If you know or suspect that someone has ingested any harmful drug, substance or chemical, or overdosed on medication, contact Poison Control IMMEDIATELY.

NATIONAL SUICIDE PREVENTION LIFELINE 1-800-273-8255
Free, confidential support 24/7 for people in distress and crisis resources for families or providers.

ADULT PROTECTIVE SERVICES

Area I (Coeur d'Alene) 1-800-786-5536
Area II (Lewiston)..... 1-800-877-3206
Area III (Boise) 1-844-850-2883
Area IV (Twin Falls)..... 1-800-574-8656
Area V (Pocatello)..... 1-800-526-8129
Area VI (Idaho Falls) 1-800-632-4813

If you know or suspect that a vulnerable adult has been abused, neglected, or exploited, contact local Adult Protective Services IMMEDIATELY.

DISABILITY RIGHTS IDAHO..... 1-866-262-3462
If you need help advocating for a disabled person.

IDAHO CARELINE ..... 2-1-1 or 1-800-926-2588
If you need help finding health and human services or social services offered through government, non-profit, and community resources, contact the Idaho Careline.

OTHER IMPORTANT NUMBERS

_____ ..... _____
_____ ..... _____
_____ ..... _____
_____ ..... _____
_____ ..... _____
_____ ..... _____
_____ ..... _____

FIRE INCIDENT REPORT

Report each fire incident occurring within the home, during which a fire extinguisher was discharged or 9-1-1 was contacted and submit it to the certifying agent within three (3) business days of the occurrence.

PROVIDER INFORMATION

The provider is the adult responsible for maintaining the home and providing care to residents.

Full Legal Name:			Certificate Number:
Telephone Number: ( )	Email:		
Physical Address:			
Physical City:		Physical State:	Physical Zip:

RESIDENT INFORMATION

Residents are the vulnerable adults living in the provider's home.

Full Legal Name:	Date of Birth:
Full Legal Name:	Date of Birth:
Full Legal Name:	Date of Birth:
Full Legal Name:	Date of Birth:

FIRE INCIDENT REPORT

Date of Fire Incident:	Time of Fire Incident: _____:_____ A.M. ☐ P.M. ☐
Origin of the Fire:	
Extent of Damage:	

How and by Whom was the Fire Extinguished:	
Injuries or deaths, if any:	
CFH Provider's Signature:	Date:

ALTERNATE/SUBSTITUTE CAREGIVER TRAINING

RESIDENT

The vulnerable adult who lives with the regular CFH provider and needs personal assistance and/or supervision.

Full Legal Name:

REGULAR CERTIFIED FAMILY HOME CARE PROVIDER

The CFH provider with whom the resident lives and who regularly provides care to the resident.

Full Legal Name:		Certificate No.:
Telephone Number: ( )	Email Address:	
Address:		
City:	State:	ZIP:

ALTERNATE/SUBSTITUTE CAREGIVER

An alternate caregiver is a CFH provider with whom the resident will be staying for a short period. A substitute caregiver is a qualified staff (i.e., has current certification in first aid and adult CPR, has completed a Department-approved medications course, and has cleared a Department criminal history and background check) who provides care in the regular CFH provider's home while he/she is unavailable.

Full Legal Name:		Alternate Care or ☐ Substitute Care
Telephone Number: ( )	Email Address:	
Address:		
City:	State:	ZIP:

RESIDENT INFORMATION AND SOCIAL HISTORY

The regular CFH provider's review of the resident's information and social history with the alternate/substitute caregiver.

The regular CFH provider has reviewed the resident's information and social history with the alternate/substitute caregiver. The alternate/ substitute caregiver is aware of how to contact the resident's health care professionals, support services, and emergency contacts. The alternate/ substitute caregiver is also aware of the resident's social history, hobbies, and interests. If alternate care, a copy of the resident's information and social history was provided to the alternate caregiver.	Regular CFH Provider's Initials: _____ Alternate/Substitute's Initials:

RESIDENT RIGHTS

The regular CFH provider's review of the resident's rights policy with the alternate/substitute caregiver.

The regular CFH provider has reviewed the resident rights policy with the alternate/substitute caregiver. The alternate/substitute caregiver is aware of these rights and agrees to protect and honor the rights of residents living in the home.	Regular CFH Provider's Initials: _____ Alternate/Substitute Initials:

BELONGINGS INVENTORY

The regular CFH provider's review of the resident's belongings inventory with the alternate caregiver (not required for substitute care).

The regular CFH provider has reviewed a list of the resident's personal possessions being brought by the resident to the alternate caregiver's home. A copy of this list was provided to the alternate caregiver. The alternate caregiver agrees that items brought with the resident or purchased by the resident will return to the regular CFH provider's home upon services resuming there.	Regular CFH Provider's Initials: _____ Alternate Caregiver's Initials:

CARE ACCORDING TO THE ADMISSION AGREEMENT

The regular CFH provider's review of the resident's care according to the admission agreement with the alternate/substitute caregiver.

The regular CFH provider has reviewed the resident's admission agreement in regards to care with the alternate/substitute caregiver. The alternate/substitute caregiver agrees to abide by this agreement.	Regular CFH Provider's Initials: _____ Alternate/Substitute's Initials:

ASSESSMENT

The regular CFH provider's review of the resident's assessment with the alternate/substitute caregiver.

The regular CFH provider has reviewed the resident's assessment with the alternate/substitute caregiver. The alternate/substitute caregiver is aware of the resident's strengths, weaknesses, risks and needs, including functional needs, medical needs, and behavioral needs. If alternate care, a copy of the resident's assessment was provided to the alternate caregiver.	Regular CFH Provider Initials: _____ Alternate/Substitute Initials:

PLAN OF SERVICE

The regular CFH provider's review of the resident's plan of service with the alternate/substitute caregiver

The regular CFH provider has reviewed the resident's plan of service with the alternate/substitute caregiver, including supervision needs and behavior management plans, if applicable. The alternate/substitute caregiver agrees to provide services to the resident accordingly. If alternate care, a copy of the resident's plan of service was provided to the alternate caregiver.	Regular CFH Provider Initials: _____ Alternate/Substitute Initials:

MEDICATIONS, TREATMENTS, SPECIAL DIETS AND ALLERGIES

The regular CFH provider's review of the resident's medication management and treatment needs with the alternate/substitute caregiver.

The regular CFH provider has reviewed orders from the resident's health care professional with the alternate/ substitute caregiver, including prescription and OTC medication (including corresponding information sheets), treatments and special diets. The resident's known allergies were also reviewed. The alternate/substitute caregiver has been supplied with the resident's medications and assumes responsibility for management of such, including refilling prescriptions before the supply is exhausted, if applicable.	If the following occur, the alternate/substitute caregiver will make the following notifications: • A dose is not taken or side effects are observed: _____ • An overdose occurs: POISON CONTROL: 1-800-222-1222
	Provider has performed an inventory of narcotics before transferring medications to alternate caregiver.
	Regular CFH Provider Initials: _____ Alternate/Substitute Initials:

OTHER TRAINING PROVIDED

_____ _____

REGULAR CFH PROVIDER'S SIGNATURE DATE ALTERNATE/SUBSTITUTE CAREGIVER'S SIGNATURE DATE

HOURLY ADULT CARE
ENROLLMENT CONTRACT

Hourly adult care, also referred to as adult day health, is a supervised, structured, paid service that may be provided in a certified family home (CFH) for up to fourteen (14) hours in any twenty-four (24) hour period to adult participants who are not residents of the home. Hourly adult care encompasses health and social services, recreation, supervision, and assistance with activities of daily living needed to ensure the optimal functioning of the participant under IDAPA 16.03.19.180.

PROVIDER INFORMATION

The provider is the adult to whom the CFH certificate is issued and who is responsible for maintaining the home and providing hourly care to the participant.

Name:		Certificate No.:
Telephone Number: ( )	Email:	
Physical Address:		
Physical City:	Physical State:	Physical ZIP:

PARTICIPANT INFORMATION

The participant is the adult receiving hourly adult care services.

Full Legal Name:		Date of Birth:
Physical Address:		
Physical City:	Physical State:	Physical ZIP:

RESPONSIBLE PARTY

The responsible party is the participant's regular caregiver.

Name:		
Relationship to Participant:		
Telephone Number: ( )	Email:	
Physical Address:		
Physical City:	Physical State:	Physical ZIP:

ALTERNATE EMERGENCY CONTACT

The provider will communicate with the alternate emergency contact if the responsible party is unavailable.

Name:		
Relationship to Participant:		
Telephone Number: ( )	Email:	
Physical Address:		
Physical City:	Physical State:	Physical ZIP:

PRIMARY PHYSICIAN

The participant's primary health care professional.

Physician's Name:	Business Phone: ( )
Practice Name:	

DIAGNOSES AND BEHAVIORS

The participant's pertinent health information.

MEDICATIONS

A current list of the participant's prescription medications. If medication management is required, the provider will assist with the following:

NAME	DOSAGE	ROUTE	TIME

KNOWN ALLERGIES

A list of the participant's known allergies. The provider will take precautions against the participant ingesting the following:

DIET

Special diets prescribed by the participant's primary physician, if applicable. The provider will ensure the participant receives/is restricted from the following:

TREATMENTS

Any treatments prescribed by the participant's primary physician, if applicable. The provider will ensure the participant receives the following:

OTHER SERVICES

Other services that the provider is contracted to provide to the participant. The provider will assist the resident with the following (check all that apply):

☐ Activities (describe, if applicable):

☐ Breakfast ☐ Lunch ☐ Dinner ☐ Other: _____

☐ Supervision (describe extent, if applicable): _____

_____

ACTIVITIES OF DAILY LIVING	LEVEL OF CARE DESCRIPTION
☐ Bathing	
☐ Washing	
☐ Dressing	
☐ Toileting	
☐ Grooming	
☐ Eating	
☐ Communication	
☐ Mobility	
☐ Medication Management	

☐ Additional Services (if necessary, attach an addendum):

PAYMENTS

The rate at which hourly adult care services will be charged. Payments will be made to the provider as follows:

☐ Medicaid (the provider will bill Medicaid for services in accordance with the participant's pre-authorized plan of service)

☐ Private Pay at $_____ per hour.

COMMENCEMENT AND TERMINATION OF SERVICES

Provisions for the start of hourly adult care services and termination of the contract.

Hourly adult care services described in this enrollment contract will commence on the _____ day of _____, 20_____.

The responsible party will give the provider _____ hours of advance notice before intending to leave the participant at the provider's home and the estimated duration of service. The provider may decline to provide services on each occasion.

To terminate this enrollment contract, the provider will give the responsible party advance notice _____ days in writing.

ENROLLMENT CONTRACT VERIFICATION

By signing below, parties enter into this enrollment contract. The responsible party further confirms that the information provided herein is true and correct to the best of his/her knowledge. The provider further acknowledges the home has the ability to provide safe and effective care to the participant as described in this enrollment contract and will provide the described services.

_____	_____
RESPONSIBLE PARTY SIGNATURE DATE	PROVIDER SIGNATURE DATE

HOURLY ADULT CARE
SERVICE LOG

SERVICE DATE

The date on which the hourly adult care services logged below were provided.

Service Date:

STAFFING & SERVICES

Document the minute of arrival and departure times for staff, residents, and participants in the corresponding hour block. Place an "X" in each intervening hour block. Staffing ratios must be at least one (1) staff to every four (4) residents and participants, combined.

	Staff Name:	Staff Name:	Staff Name:	Staff Name:	CFH Resident Name:	CFH Resident Name:	CFH Resident Name:	CFH Resident Name:	HAC Participant Name:	HAC Participant Name:	HAC Participant Name:	HAC Participant Name:	HAC Participant Name:	HAC Participant Name:	HAC Participant Name:	HAC Participant Name:
12:00 AM																
1:00 AM																
2:00 AM																
3:00 AM																
4:00 AM																
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10:00 PM																
11:00 PM																

CERTIFIED
FAMILY HOME PROGRAM

RECERTIFICATION CHECKLIST

IDAHO DEPARTMENT OF HEALTH & WELFARE

This checklist will assist you in preparing for recertification. Update your records listed on this checklist and have them (along with your permanent records, like proof of home ownership or lease agreement) ready for the certifying agent to inspect at the time of your recertification survey. **Your residents MUST be home at the time of the survey.**

HOME RECORDS
□ Current First Aid and CPR Certificates
□ Documentation of Ongoing Annual Training ▪ Type: At Least Half Interactive Training; Remainder may be Independent Study ▪ Content: At Least Half Resident-specific; Remainder may be General Topics
□ Current Homeowner's or Renter's Insurance
□ If Applicable, Lab Results within Past Year on **Private** Water Supply Showing Absence of Bacterial Contamination
□ If Applicable, Proof of Septic Tank Service within Past 5 Years for **Nonmunicipal** Sewage Disposal Systems
□ Emergency Preparedness Log
□ Video Evidence of Fire Drills (preferred) or Completed Fire Drill Summaries
□ If the Home is So Equipped, Receipts for Inspection of **Fuel-Fired Heating Systems** (e.g. Gas Furnace/Fireplace, Wood/Pellet Stove) Conducted within the Past Year
□ Receipt for Servicing or Purchase of Dry Chemical, Multipurpose, 2A:10B:C Type Fire Extinguisher(s) within Past Year (Must be at Least 5 lb. Fill Weight)
□ Current Phone Bill
□ Emergency Contacts, Either: ▪ Programmed into the Phone ▪ Posted Near the Phone
□ If Applicable, Qualifications for Substitute Caregivers you are Currently Using: ▪ Current First Aid And CPR ▪ Department-approved Medication Course ▪ Department Criminal History and Background Check
□ If Applicable, Alternate/Substitute Caregiver Training
□ Criminal History Clearances for Any New Adults (Excluding Residents) Living in the Home
□ If Offering Hourly Adult Care: ▪ Enrollment Contract for Each Participant ▪ Service Logs for Each Day Services were Provided
□ Renewal Application

ADMISSION RECORDS
□ Current Admission Agreement
□ Updated Resident Information and Social History
□ If the Resident has a Representative, the Legal Document Authorizing the Appointment
□ Resident Rights Policy Review Log
□ Advance Directive Notification ▪ Living Will and Durable Power of Attorney, if the Resident So Chooses to Complete

□ Belongings Inventory – Reviewed within Past Year *(Inventory May Be Photographs, But Review Date Must be Documented)*
□ Results from Most Recent History & Physical Examination ▪ Full Results, NOT the Adult DD Medical Care Form
□ Current List of Medications Signed/Dated by Resident's Health Care Professional ▪ Prescriptions List from Pharmacist or Included on the Resident's History & Physical Examination ▪ Non-Prescriptions Listed on Over-the-Counter (OTC) Medications Form
□ If the Resident is Responsible for Own Medications, the Approval to Self-Administer Medication Form
□ Most Recent Assessment ▪ Scales of Independent Behavior - Revised (SIB-R) or Supports Intensity Scale - Adult (SIS-A) for Residents Receiving Services Through Developmental Disabilities (DD) Waiver or Self Direction ▪ Uniform Assessment Instrument (UAI) or Findings for Residents Receiving Services Through Aged & Disabled (A&D) Waiver, Medicare/Medicaid Coordinated Program (MMCP), Idaho Medicaid Plus, State Only Personal Care Services (PCS), or Similar for Private Pay
□ Most Recent Plan of Service ▪ Individual Support Plan (ISP) for Residents Receiving Services Through DD Waiver ▪ Support and Spending Plan (SSP) for Residents Receiving Services Through Self Direction ▪ Service Agreement for Residents Receiving Services Through A&D Waiver, MMCP, Idaho Medicaid Plus, State Only PCS, or Similar for Private Pay
□ If Applicable, Signed Copy of Any Care Plan that is Prepared for the Resident from Other Service Provider

ONGOING RESIDENT RECORDS
□ If Provider Manages Resident Funds: ▪ Resident's Bank Statements ▪ Resident Cash Ledger ▪ Receipts for Purchases Over $5
□ If Money Lent to Resident, Personal Loan Contract
□ If Provider Assists Resident with Medications: ▪ Narcotic Inventory, If Applicable ▪ Medication Assistance Records ▪ Medication Disposal Records
□ Incidents / Accidents / Changes of Condition
□ Grievance Response Records
□ If Applicable, Notes from Other Service Providers for Each Visit to the Home